STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155783	A. BUILDING 00 B. WING	06/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENLEAF HEALTH CAMPUS	1201 E BEARDSLEY ELKHART, IN 46514

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R0000	This visit was for the Investigation of Complaint IN00109804 Complaint IN00109804-Substantiated. State residential deficiency related to the allegation is cited at R052 Survey dates: 6/25-26/12 Facility number: 002661 Provider number: 155783 AIM number: N/A Survey team: Ellen Ruppel, RN Census bed type: SNF: 26 SNF/NF: 5 NCC: 45 Residential: 26 Total: 102 Census payor type: Medicare: 26 Medicaid: 5 Other: 71 Total: 102 Residential sample: 3 This state finding is cited in accordance with 410 IAC 16.2	R0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Quality review completed on June 27, 2012 by Bev Faulkner, RN			

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R0052	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on observation, interviews and record review, the facility failed to ensure 1 of 3 residents at risk of elopement from the secured memory unit was provided with supervision to prevent egress from a window and elopement from the facility to another city in a neighboring state. Resident B Findings include: The clinical record of Resident B was reviewed, on 6/25/12 at 9:20 a.m., and indicated the resident had been admitted to the secured unit of the facility on 6/7/12, between 2:00 p.m., and 3:00 p.m. The record indicated she had been admitted from the hospital. The facility pre-admission assessment, dated 6/5/12, indicated mild cognitive impairment. An area on the pre-admission form which indicated "Resident has not exhibited indication of danger to self or others" was completed with the statement "other than wandering	R0052	1. Resident B was assessed on 06/08/12 with no ill effects noted. Resident B was admitted to psychiatric unit on 06/09/12 and remains there.2. All residents on the Legacy Assisted living unit that could have the potential elopement risks were re-evaluated to ensure all measures were in place. 06/09/12Any new admits will be evaluated prior to admission for appropriateness to Legacy Lane, and discussed by interdisciplinary team before admission. 07/10/12.3. All staff in-serviced on elopement risks on 06/09/12. All staff inserviced on Resident Rights. 06/30/12. All window cranks from windows on the Legacy Assisted living unit were removed on 06/08/12 and nurses have access to cranks to open windows for residents. Window opening re-measure and windows on Legacy Assisted living unit only open 6 inches. 06/09/12.4. Continued resident appropriateness will be discussed at a minimum of once during the first 7 of admission and monthly thereafter or sooner if warranted, with resident's responsible	06/30/2012

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	outside of her home." The hospital consult, dated 6/6/12, indicated the resident had been taken to the hospital by her daughter the previous night due to progressive confusion and dangerous behaviors in the community. The consultation indicated the police had picked her up after finding her wandering in the streets. The note also indicated she had been given a mini mental exam and scored 6 of 30, indicating cognitive impairment. The recommendation included placement in a locked unit of a nursing home. The physician indicated," The patient has a very severe, end-stage dementia at this point and will absolutely need a locked unit." The hospital transfer record, dated 6/7/12, indicated the resident had a history of falls within the past 60 days and wandered. Nurses notes of 6/7/12 with the time listed as 8:40-10:00 p.m., indicated "up dressed-packed & (and) ready to leave-please call a taxi or my son-I'm leaving. I can't sleep." A nurses note at 5:00 a.m., on 6/8/12, indicated the resident had been up and down most of the night and had slept 3 hours.		party.Residents identified with significant risk factors will be evaluated to ensure the environmental capabilities are appropriate. We will assess resident risk factors by observing patterns and if resident not easily re-directed then the Interdisciplinary team will be a part of meeting to help assist with discussion of appropriateness and possible interventions.Will discuss with family. 06/09/12. If resident is not easily redirected and all interventions have been tried then exta staff may be added until apporopriate placement can occur. 07/10/12 .5. Quality Assurance committee will evaluate process 1x monthly for 3 months for appropriateness of residents on the Legacy Assisted living unit and then after 3 months evaluate need to continue or resolve issue.09/30/12.	

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The next note at 7:00 a.m., indicated the resident was pacing up and down the hallway and trying to exit the unit. It also indicated she had hit and pinched the nurse. The resident's daughter was notified and visited at the facility, requesting the facility notify the medical group.

Late entry nurses notes for 6/8/12 at 8:00 a.m., indicated the resident had been exit seeking and watching the doors.

Nurses notes of 6/8/12 at 9:35 a.m., indicated the facility nurse had contacted two psychiatric groups for admission and neither was able to accept the resident at the time.

Nurses notes at 6:00 p.m., on 6/8/12, indicated Resident B had packed her bags and was going door to door to get out. The son-in-law was notified of her attempts to elope. The note indicated, in part...."CNA (certified nursing assistant) and this nurse kept an eye on resident thru bedtime."

The next note at 8:00 p.m., on 6/8/12 indicated the resident was in bed.

Nurses notes at 8:05 p.m., on 6/8/12 indicated the aide went to the room and

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	found the resident was not in her room. A search was begun and the window in the room across from Resident B's room was found to have been open. Police were notified and at 8:22 p.m., were in the facility and a search had begun, according to the nurses note at 8:22 p.m., on 6/8/12. A nurses note at 10:30 p.m., on 6/8/12, indicated the resident had been found in the city where she had previously lived, which is in another state and within 18 miles of the facility. The nurses note at 12 a.m., on 6/9/12, indicated the resident had been returned to the facility in the daughter's family car. The note indicated 15 minute checks were begun and the note indicated the resident was "adament (sic) that she is not staying here." Nurses notes at 12:35 a.m., indicated the resident was up pacing and a dose of klonopin was given (seizure medication also used for behavioral issues). At 1:30 a.m., the nurses note indicated the resident was asleep. Transfer information indicated she was sent to a psychiatric unit on 6/9/12 at 1:00			

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	p.m. The window in the room where Resident B had eloped from was observed with the Director of Nursing (DON) on 6/25/12 at 9:00 a.m., and found to be blocked when opened approximately six inches. The window was a crank out window with a screen in place. The window sill was about waist high with a large stone ledge. The DON indicated the window had been blocked at the same opening capability when Resident B had gotten out, and the crank had been on the window. Since the elopement, the crank had been removed and only nurses could open the windows. When queried on 6/25/12 at 9:00 a.m., about the room across from Resident B's room being unlocked, the DON indicated the facility had no specific policy for leaving vacant rooms unlocked and the room had been used as a "show room" for prospective new residents. On 6/25/12 at 2:45 p.m., the CNA (#1) who had been working the evening of 6/8/12, was queried about Resident B's elopement and she indicated she had gotten Resident B ready for bed three times between 7:00 p.m., and 8:00 p.m., on 6/8/12. She indicated the resident kept taking her night clothes off and getting dressed and when she checked on the			

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	resident at 8:05 p.m., on 6/8/12, the resident was gone. CNA #1 indicated the screen had been pushed off the window in Resident B's room and in the room across the hall. Both rooms were observed to be at the far end of the hall away from the nurses desk. CNA #1 indicated she thought the vacant room across from Resident B's room was locked the evening of 6/8/12, and had not checked it prior to the resident's elopement. Resident B's room was observed, on 6/25/12 at 2:50 p.m., to be on the side of the facility with the window opening into an enclosed courtyard. If she had exited through the window in her room, she would have been in an enclosed, locked area with a high fence. The nurse (LPN #2) who had been working the evening of 6/8/12, was queried on 6/25/12 at 2:50 p.m., about the incident. She indicated Resident B had called her family the evening of 6/8/12 and told them she was leaving, but family members had not let the facility know. LPN #2 also indicated the resident had packed her belongings and staff members were aware she wanted to leave. LPN #2 also indicated the resident had removed the screens from both rooms and put them under the bed in each room and when she was returned to the facility, she told the			

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	nurse she had removed them and had realized the window in her room led to an enclosed courtyard, so she went across the hall to the room where she could get out into the parking lot. The nurse indicated she did not know how the resident got from the facility to the out of state city, but thought the police had mentioned that the resident went to the local fast food restaurant and someone there helped her get a ride to her former home. LPN #2 indicated she had been unaware the vacant room had not been locked prior to Resident B's elopement. During an interview with Resident B's family member, on 6/25/12 at 3:00 p.m., the family member indicated the resident had known her home address and had told the family member that a truck driver picked her up and took her to the out of state area. There was no documentation to indicate the resident had been placed on one to one supervision or to indicate an outside agency had been provide additional monitoring of the resident during her stay at the facility. This state residential tag relates to Complaint IN00109804			

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